

CLOSING THE GAP

■ Office of Minority Health ■ Public Health Service ■ U.S. Department of Health and Human Services ■

Cancer in Minority Communities

Employing Innovative Approaches

IN San Diego, some know Silva Jurich as the Swap Meet Queen. "Swap meets are where the people in my community shop, so that's where we go to reach them," says Ms. Jurich, cancer screening project director at La MAESTRA Family Clinic. La MAESTRA is the lead agency of the OMH-funded San Diego Latina Cancer Coalition, a group of clinics, health care providers, and legislators. The coalition strives to identify health issues related to breast and cervical cancer, develop plans to address needs, and shape official policies.

Charged with motivating low-income Hispanic women to participate in breast and cervical screening, Jurich and the clinic's medical team seize any chance they can to visit community meeting spots. They transport a mobile mammography van and a truck filled with exam tables, screens, and medical supplies. "Not only do women learn that we think enough of them to come to their door," Jurich said. "We're also showing them that cancer screening is important and that we understand the obstacles they face."

To reach older women, outreach workers set up rooms in Sunday schools where up to 60 women are screened during one time period. These personal strategies carry a lot of weight since many of the women Jurich targets have never experienced a pelvic exam, let alone been warned about the possibility of cancer. Encouraging women to tread into unfamiliar territory can be a challenge, Jurich admits, but it helps that her staff members are of the same ethnicity and socioeconomic background as the patients. It's something that lends a dimension of credibility to the clinic's mission. "When women see that our workers shop, pray, and live in the same places they do, they identify with us."

Facing the Financial Crunch

The number of minorities without money and health insurance continues to rise, especially with the increasing number of immigrants entering the United States. La MAESTRA is committed to helping women in San Diego find treatment, but it's a difficult undertaking. And Proposition 187 is threatening to make matters worse, Jurich said. The California law requires medical providers to limit services for illegal immigrants to those emergency services mandated by the federal government, and to report illegal immigrants to the authorities. An injunction was filed to prevent the law from taking effect pending a court hearing, and as a result, no changes have been made in California's Medicaid program (Medi-Cal), according to the state's Health and Welfare Agency.

Currently, only people with documented immigration status are eligible for full-scope Medi-Cal, which covers a wide range of preventive and health care services. Persons without documented immigration status are eligible only for a restricted Medi-Cal program, encompassing federally mandated emergency services and pre-natal and long-term care services. This allocation existed before Proposition 187 and still stands today. But since undocumented immigrants may receive only limited services under Medi-Cal, Jurich said, "some women are having to wait until cancer has spread before they can have breast surgery." So while it is true that the full range of treatment is available to U.S. citizens enrolled in Medi-Cal, the prospects for undocumented immigrants with cancer remain grim. The San Diego Latina Cancer Coalition has been able to recruit physicians who are willing to perform surgical procedures pro bono. But the challenge ahead will be continuing to establish such sources of treatment, while enacting policy changes that improve access to care. For more information about La MAESTRA, call 619-584-1612. ■

MCH Programs Support Cultural Competency

MARGARET Teng Lee, M.D., says she still had a lot to learn when she graduated from medical school in the 70s. "Only by experience have I found out about the cultural sensitivity that's needed to treat patients."

As a maternal and child health (MCH) care consultant for the Public Health Service (PHS), Region II (New York, New Jersey, Puerto Rico, and the Virgin Islands), Dr. Lee has served as a federal resource person for Asian organizations. Currently responsible for programs on both maternal/child health and family planning, Dr. Lee helps agencies identify appropriate health care practices for underserved populations.

She cites stomach, esophageal, and liver cancers as more prevalent

in the Asian and Pacific Islander communities. A major reason why rates of liver cancer are so much higher among Asians and Pacific Islanders is because these populations have a high prevalence of chronic carriers of Hepatitis B. "Studies have shown that there is a strong correlation between this virus and hepatocellular carcinoma (liver cancer)," according to Winston Wong, M.D., a PHS clinical coordinator for Region IX (Arizona, California, Hawaii, Nevada, American Samoa, Guam, and the Pacific jurisdictions.)

Both Drs. Lee and Wong assert that treating cancer in members of any ethnic or racial group requires cultural sensitivity.

For example, it's important to recognize, said Dr. Wong, that it may be problematic to have a Caucasian, western-trained male

doctor treating an older Vietnamese woman with cancer, simply because of the potential for cultural misunderstandings.

Most western doctors don't know about Asian perceptions of death and dying. "I've had a lot of patients," he said, "whose family members ask me not to tell the patient that he or she has cancer." This is because the patient views cancer as a terminal disease, he explains, and will probably be unwilling to receive treatment. The proper way to handle such a request is to inform patients of the truth, and work with the entire family on the cultural implications of making a diagnosis. "Asian patients see their health as part of the health of a whole family."

Another point health providers need to be more aware of is that even after coming to this country, many people continue to use herbal and other traditional medicines, said Dr. Lee. Since some patients are reluctant to reveal cultural practices, the result can be a dangerous mixing of drugs that may have adverse effects on the patient, she added.

Clinics should also consider that health promotion and disease prevention don't normally rank high in the eyes of immigrants. "They are struggling with housing, education, and job issues, not to mention lack of health insurance," Lee said.

The encouraging side is that PHS supports the training of health providers to acknowledge these issues. The consensus seems to be that leaving cultural competency out of health care will only send minorities a step backward.

Through cultural competency training, health providers learn valuable information such as how to recognize genetic factors associated with ethnic groups or how to broach cultural issues during a medical exam. ■

Immigrant Health Training, PHS Region II

There has been tremendous growth in the number of immigrants from the Caribbean, Central and South America, Russia, the Middle East, and Asia into Public Health Service (PHS), Region II. About 4 percent of the population in New York is Asian, with more than 80 percent living in New York City. To better equip Region II maternal/child practitioners to serve growing immigrant populations, PHS funds the Maternal Child Immigrant Health Training Program. The program aims to enhance health providers' knowledge of cultural issues and provide effective cross-cultural interview and diagnostic treatment skills. Five training modules have been implemented at 10 maternity/infant care centers and six pediatric resource centers in New York City. The training modules include The Cross Cultural Medical Interview and Working With Interpreters; Epidemiological Factors Affecting Immigrant and Refugee Health; Attitudes and Practices in Maternal Child Health; and Family Dynamics and Domestic Violence. The Region II MCH program also works with Grantmakers in Health, a group of private foundations, to fund increased dissemination of health education materials and to improve the quality of training for medical translators. For more information, call 212-264-2531.

Minority Health Perspective

Making a Difference Together

By Clay E. Simpson, Jr., PhD
Deputy Assistant Secretary for Minority Health

The Office of Minority Health (OMH) urges you to support National Breast Cancer Awareness Month during October and the Great American Smokeout on November 17. Sponsored by the American Cancer Society (ACS), these events provide excellent opportunities to advance the message of the importance of cancer prevention and treatment.

During Breast Cancer Awareness Month, ACS will target women who are older, African American, Spanish-speaking, and those in rural areas through its *Tell A Friend* program. This program encourages women to inform others about the benefits of early detection. For the Great American Smokeout, ACS will use the theme *You're Too Smart to Start* in an effort to reach adolescents.

Due in part to collaborative efforts between OMH and other government agencies, health providers, and health organizations, there has been significant progress in the use of screening as a means of reducing mortality associated with breast and cervical cancer. Culturally appropriate interventions have played a major role in increasing access to screening. More African American and Hispanic women are being screened now than ever before. As a result, there have been improvements in early detection, diagnosis, and treatment.

I know that our readers are an integral part of these improvements, and I salute your efforts to carry out successful cancer education and screening programs. It is critical for all of us who work on behalf of disadvantaged and disenfranchised communities to continue to work together.

We must work together to empower everyone to take responsibility for their health. It is our job to provide minorities with accurate, up-to-date, and culturally sensitive information about the risk of cancer and treatment options. We must empower people to adopt healthy lifestyles and practices, such as breast self-examinations. Moreover, we must empower our people to become active participants in making decisions that affect health.

For more information on National Breast Cancer Awareness Month and the Great American Smokeout, call ACS at 1-800-ACS-2345. To request articles or a database search on information related to cancer, call the OMH Resource Center at 1-800-444-6472.

The Effect of Culture on Diet and Weight

Being 40 percent or more overweight puts you at increased risk for colon, breast, prostate, gallbladder, and ovarian cancers, according to *Cancer Facts & Figures 1994*, published by the American Cancer Society. Regardless of whether you're overweight, consuming a diet high in fat may contribute to the development of certain cancers. Experts contend that attitudes about food and weight are largely influenced by culture. It's an assertion to be recognized since cancer rates for African Americans are generally higher than those for whites. "Although data on the eating habits of African Americans is scarce, it appears that African Americans have traditionally eaten more high-fat foods than whites," according to Gwendolyn Pla, Ph.D., who teaches nutrition at Howard University. "It's something that goes back to southern roots." Additionally, obesity seems to be more accepted among African Americans, she said. Dr. Pla has treated African Americans and whites with eating disorders, and she has found that her white patients seem more concerned about thinness. "Whites are more likely to have anorexia, whereas for Blacks, eating disorders tend to be more of a binge nature. They're not worried about food making them fat; they're eating a lot to feel better." For a copy of the *Directory of African American Nutrition Programs*, call the OMH Resource Center, 1-800-444-6472.

Seven CBOs Participate in Ohio Screening Project

With funding from the Centers for Disease Control and Prevention (CDC), the Ohio Commission on Minority Health and the Ohio Department of Health teamed up with seven community based organizations (CBOs) to provide information, education, and referrals for breast and cervical cancer screening. The six-week pilot project ran from May to mid-June. The first five weeks focused on identifying women for screening and referring them for medical treatment, and the final week consisted of follow-up activities. Though the project's time period was short, 960 women were identified and referred, according to Cheryl Boyce, Executive Director, Ohio Commission on Minority Health. "That's because the CBOs know best how to reach the people and bring them in," she said. There were two CBOs targeting Asians, two targeting African Americans, two targeting Hispanics, and one targeting Native Americans. "A big plus," said Ms. Boyce, "was that we got to involve small CBOs who may have never had an opportunity to participate in a federal project." State agencies combined their strengths, she added, and underserved women gained access to care. *For more information, call the Ohio Commission on Minority Health, 614-466-4000*

Resources at the American Cancer Society

SINCE 1988, the American Cancer Society (ACS) has funded more than 100 community demonstration projects to provide cancer education messages and programs to minorities.

The organization provides information and assistance on all topics or concerns related to cancer. Through state and local chapters, ACS offers information, publications, and community and school programs focusing on detection, treatment, and control of cancer.

A guiding philosophy of the organization is that cancer control in any population can be accomplished best by *individuals in that population*. To implement community-based efforts, ACS looks to its local volunteers.

The best place to begin if you're interested in joining ACS in its mission is with your local Unit office, which is listed in the phone book. Here are some of the national ACS resources and contact persons:

- **Advocacy:** The ACS Government Relations Office in Washington, DC, educates policymakers about cancer. The society advocates for public policy initiatives that improve the welfare of cancer patients and their families. Contact: Kerrie Wilson, 202-546-4011.
- **Collaboration:** ACS is involved in a movement toward planned, nationwide collaboration with specific groups, including minorities. Contact: Laura Greiner, 404-329-5762.
- **Epidemiology:** By the end of 1995, ACS will complete *Facts & Figures for African Americans*. Each year thereafter, the society will produce a similar report on other ethnic minority groups. Contact: Sherry Bolden, 404-329-7990.
- **Community Connection:** Resources, Information, and Guidance: This program provides information on cancer and ACS services to meet the practical, social, psychological, and other support needs of cancer patients and their families. Contact: Angie Satterfield, 404-329-7609.
- **Prevention:** ACS has developed several prevention programs, including "Tell a Friend." This program is based on encouraging women to tell their friends about having mammograms. With training and support from their ACS units, volunteers help friends make and keep mammogram appointments. Contact: Mary O'Connell, 404-329-7687.
- **Materials:** To order cancer educational materials, contact your local Unit or Division office of ACS. For general information about ACS publications and how cultural sensitivity issues are handled, contact Beverly Greene, 404-329-7911. ■

AHCPR Offers Guidelines on Managing Cancer Pain

THE Agency for Health Care Policy and Research (AHCPR) has developed clinical practice guidelines on managing and controlling cancer pain.

These guidelines were systematically developed in consultation with expert panels to help practitioners and patients decide on appropriate health care for specific clinical circumstances.

Minorities are typically diagnosed with cancer when the disease is advanced, making treatment options limited and pain unbearable. Researchers have even found that minority patients who suffer pain as a result of cancer are generally three times more likely to receive inadequate pain treatment than non-minorities.

In approximately 90 percent of cancer patients, pain can be controlled by relatively simple means, according to the guidelines. An aggressive approach is recommended because unrelieved pain affects a patient's ability to cope physically and psychologically with the disease.

AHCPR guidelines cover strategies for managing pain in various types of people, including children, elderly people, HIV/AIDS patients, and substance abusers.

For single, free copies of *Clinical Practice Guidelines, Management of Cancer Pain: A Quick Reference Guide for Clinicians*, write to "Cancer Pain Guidelines", AHCPR Publications Clearinghouse, PO Box 8547, Silver Spring, MD 20907. ■

Health Programs Require Cultural Consideration

Assertive behavior signals disrespect in some cultures. According to experts, such a belief is intrinsically linked to the way one views health care. Lack of assertiveness, for example, could cause a patient to shy away from asking questions in the doctor's office.

In an article published in the *Journal of Health Care for the Poor and Underserved*, the North Carolina Native American Cervical Cancer Prevention Project is described as a project that responded to cultural issues throughout its development. With funding from the National Cancer Institute, National Institutes of Health, the project was launched to prevent cervical cancer among Cherokee and Lumbee tribes in North Carolina.

*...all women should be able to
complete the full circle of their lives.*

The project's initial approach to deliver educational materials involved strong commands, such as "Get a Pap Smear." But in light of an Indian cultural view that such bluntness can be offensive, the project substituted softer, more positive messages such as "American Indian Women Are Important. Act Now to Prevent Cancer."

When possible, implementing culturally sensitive messages right from the start is preferable to making adaptations along the way. "Little progress can be made if cancer control or other health education programs are introduced into an American Indian community without first attempting to understand and appreciate the culture...," the researchers state.

Using committees of community health representatives (CHRs) and focus groups to test the waters are some effective tools, says Nancy Hane, RNC, MS, a cancer survivor and volunteer with the American Cancer Society (ACS). Ms. Hane has helped implement Circle of Life, a breast cancer education program for Native Americans/Alaska Natives that began in the ACS Oklahoma Division in 1991 and has expanded into a national program. The title, Circle of Life, stands for the idea that all women should be able to complete the full circle of their lives.

The culturally relevant program trains Native American women and health care providers to teach about the importance of mammography and clinical and self breast exams. ACS' Oklahoma Division zeroed in on Native Americans, Hane said, because the population has a much lower survival rate five years

after a cancer diagnosis than white women and because Oklahoma has the largest Native American population in the United States.

ACS worked with state health departments, the Indian Health Service (IHS), and various tribes to develop the three-hour training session, which makes use of a flip chart, pamphlet, training guide, and video. A committee of CHRs, IHS nurses, and volunteers evaluated each component of the program. "Since younger women really listen to older women in the Native American community," Hane said, "committee members wanted an older woman to do the narration for the video." ACS also found that people wanted to see a woman demonstrate the breast self-exam in a modest way, so her face is never shown. The beginning of the video was well-received because it shows the many avenues of a Native American woman's life—dancing at a pow wow, running, working, and caring for her child.

In 1993, Hane presented the Circle of Life program at regional meetings in Montana and Minnesota to give CHRs an opportunity to critique it, and so that she could compare feedback from different states. "We found that we had to change the wording in our literature to accommodate different reading levels," she said. And both groups wanted to learn more about the artwork for the program, so that information was added to the training manual.

Native American artist Dana Tiger volunteered to design the Circle of Life logo, which depicts a Native American woman under the moon, with one hand across her breast and the other holding a staff. "My vision," said Ms. Tiger, "was to show an Indian woman as she has always been—with determination and extreme courage to take charge of whatever situation arises." ■ *For more information about the Circle of Life program, call the ACS Oklahoma Office at 405-843-9888.*

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Intercultural Cancer Council Calls for Joining Forces

WHEN Lovell Jones, Ph.D., learned in May of 1979 that his mother had breast cancer, "everything struck home," he said. "Cancer doesn't stop anywhere—not at economic levels and not at race."

Given the way cancer is wiping out populations, minorities evidently have more common problems than they do differences, Dr. Jones said at a meeting held in April at the Office of Minority Health (OMH) in Rockville, Maryland. Dr. Jones, professor and director of experimental gynecology/endocrinology at University of Texas MD Anderson Cancer Center, is one of OMH's external consultants who helps keep the office informed of new developments in minority health.

Undoubtedly, cancer statistics are right in sync with Dr. Jones' view. African Americans have the highest cancer rates overall. Hispanic women are nearly twice as likely as white women to develop

cervical cancer. Chinese Americans are more likely than any other group to develop liver cancer and die from it. Native American cancer patients are the least likely to survive five years after a cancer diagnosis, and the list goes on.

Such commonalities, he said, have made it imperative that minority groups exercise power in numbers. The new Intercultural Cancer Council (ICC), representing a formal joining of minority forces, kicked off in April at the 5th Biennial Symposium on Minorities, the Medically Underserved & Cancer, held in Arlington, Virginia.

Dr. Jones, who served as co-chairman of the conference, is founding chairman of the ICC. "Though the ICC will stand for many minority groups in one culturally diverse country," he said. "we will speak with one voice in Washington." The council will help prevent individual groups from getting caught up in "competing for

a small piece of the pie."

The main mission of the ICC is to promote public policy changes around cancer and minorities. The council calls for the opposition of congressional plans for block grant approaches that would remove federal support for cancer programs; improvements in national epidemiological studies of cancer among minorities; and stronger controls on tobacco, including cigarette tax increases.

The list of ICC members is long, and includes Howard University Hospital, the Association of Asian Pacific Community Health Organizations, the American Cancer Society, the Kellogg Company, and the National Coalition for Cancer Survivorship.

"If we don't begin to operate as a unified front," Dr. Jones said, "we will continue to face cancer in disproportionate numbers."

For more information about the Intercultural Cancer Council, contact Pamela M. Jackson, 713-798-4617.

Promoting Health Care

AFTER you watch several beverage commercials, you start to get thirsty. According to Elmer Huerta, M.D., M.P.H., this age-old marketing principle of repetition works for health care too. "The only difference is that I'm 'selling' pap smears, mammograms, and other cancer screening tests," he said.

Dr. Huerta, cancer prevention specialist at the Washington Cancer Institute, Washington Hospital Center, has talked about cancer prevention for five years on a radio show run by WILC AM, a Spanish-language station in Washington, DC. Approximately 200,000 listeners tune in to the five-minute show, which airs three times a day.

Dr. Huerta has used the radio program as the sole vehicle to promote a cancer screening clinic that he started at Washington Hospital Center in 1994. The clinic initially opened on a schedule of two days a week. Now, Dr. Huerta has bumped it up to three days because of demand. "We have seen more than 800 patients in ten months, and there's a waiting list because so many people want to get in." About 95 percent of his patients are Hispanic.

A visit to Dr. Huerta's clinic costs \$35. This flat rate gets you approximately 45 minutes with him—time that he spends performing a complete physical exam, conducting any necessary cancer

screening tests, recording medical history, and discussing risk factors for cancer.

"I have seen a lot of fatalistic attitudes among my patients," he said. "Some feel that since God has set up destiny, there's no point in intervening." But Dr. Huerta shows them how behavior can have a significant impact on health, and that behavior is always changeable.

The Washington Cancer Institute is a member of the newly formed Intercultural Cancer Council, and Dr. Huerta expects that the group will give politicians a push and trigger significant improvements in minority health. "Minorities are suffering a cancer burden that must be recognized."

African American Men Suffer High Rates of Prostate Cancer

SHAPED like a walnut in young men and doubling in size by age 60, the prostate is a male sex gland located below the bladder.

The fact that most men rarely think about the prostate is troublesome considering that prostate cancer is the most commonly diagnosed form of cancer among men in the United States, according to the Centers for Disease Control and Prevention (CDC).

In 1995, an estimated 244,000 new cases of the disease will be diagnosed and approximately 40,400 men will die, despite advances in surgical and medical therapy. Prostate cancer often occurs at a later age when other medical conditions such as heart disease and stroke may contribute to the cause of death, so it is unclear how many men are dying with prostate cancer rather than from it.

What is crystal clear, however, is that African American men have the highest incidence of prostate cancer of all racial and ethnic groups in the United States. And the rate at which they die from the disease is almost three times higher than whites.

"when you don't have health insurance, you tend to get a very different quality of care."

The Radiation Therapy Oncology Group (RTOG) is a national cancer research organization made up of more than 200 medical facilities across the country, as well as Canada. Administered by the American College of Radiology and funded by the National Cancer Institute (NCI), RTOG conducted a recent round of studies on prostate cancer.

Researchers found that African American men with the disease live as long as their white counterparts when they receive the same treatment. But unfortunately, African American men are not receiving comparable treatment, according to Mack Roach, M.D., assistant professor of radiation oncology and medical oncology at the University of California, San Francisco. The university's medical center is a member of RTOG.

African American men are being treated when the disease is more advanced, a difference probably due to whites' greater awareness about cancer and greater access to health care, explained Dr. Roach.

"When you look at surveys on cancer," he said, "you find that a larger percentage of African Americans don't have health insurance. And when you don't have health insurance, you tend to get a very different quality of

health care."

The high rate of prostate cancer and mortality among African Americans has been seen only in the last few decades, according to NCI, suggesting that it may be caused by diet or environmental factors.

Dr. Roach agrees, noting that Blacks in Africa don't have prostate cancer rates as high as Blacks in this country. There are many cases where cancer incidence among members of a population increases when they come to the United States, he said, supporting the idea that lifestyle factors may loom larger than biological ones.

In 1993, Congress authorized CDC to develop state-based demonstration projects for prostate cancer, working in tandem with existing cancer control efforts in state health departments. Currently established in Central Harlem in New York, rural northwest Louisiana, Massachusetts, and Missouri, these demonstration projects are assessing attitudes, beliefs, and practices about prostate risk and screening, particularly among African American men, ages 50 to 75.

Results of a similar study on attitudes, conducted by the Fox Chase Cancer Center and the University of Chicago and funded through NIH, showed that health education messages facilitated prostate screening among African Americans when those messages described the screening as convenient, effective, and easy, and when they stated that African American men are at increased risk in comparison with whites.

Since a man's chances of having prostate cancer increases with age, with most cases occurring after 60, the American Association of Retired Persons (AARP) recently produced a series of public service announcements on the subject in cooperation with NCI. Veteran actor Ossie Davis urges African American men to learn more about the "silent killer stalking their lives," a crucial point since there are no early signs of the disease.

AARP has also published *Staying Strong, For Men Over Fifty*. The health guide discusses symptoms, risk factors and treatment options for several diseases, including prostate cancer, colorectal cancer and lung cancer. ■

For a free, single copy of the AARP guide, contact: AARP Fulfillment (EE0870), 601 E St., NW, Washington, DC 20049. Also available is *Chances Are...You Need a Mammogram*.

For more information on the Radiation Therapy Oncology Group, write to Keri Sperry, 1891 Preston White Drive, Reston, Virginia 22091.

The Prostate Health Council offers a series of patient education booklets, including *Prostate Cancer: What Every Man Over 40 Should Know*. For free, single copies, write the Prostate Health Council, c/o the American Foundation for Urologic Disease, 300 West Pratt St. Suite 401, Baltimore, MD 21201.

National Action Plan on Breast Cancer

TWO decades ago, a woman's lifetime risk of developing breast cancer was one in twenty. These days, the risk is one in eight. It's no wonder that 2.6 million people signed a petition calling for the establishment of a comprehensive strategy to end the breast cancer epidemic.

That petition was formally presented to President Clinton in October 1993, and the U.S. Department of Health and Human Services (DHHS) was asked to respond. That following December, HHS Secretary Donna Shalala convened advocates, consumers, scientists, and members of Congress for the Secretary's Conference to Establish the National Action Plan on Breast Cancer (NAPBC).

What resulted was a public/private partnership that aims to build and strengthen knowledge, resources, and commitment to the goals of preventing, detecting, diagnosing, treating, and ultimately eliminating breast cancer.

The Public Health Service's (PHS) Office on Women's Health (OWH) is at the helm of efforts to implement NAPBC, which includes coordinating activities with other agencies and administering grant programs.

Six working groups have been established to address the priority areas of the NAPBC: clinical trials, etiology, consumer involvement, information access, biological resources banks, and genetic testing.

Minorities are important to all of these areas since OWH will work on increasing minority participation in research trials and identifying new strategies to educate minority groups about breast cancer.

"Between 1989 and 1992, there was a decrease in mortality rates of more than five percent for white women with breast cancer, but approximately a three percent

increase for African American women," according to Susan Blumenthal, M.D., Deputy Assistant Secretary for Women's Health and Director of OWH. "That may be attributable to the fact that African Americans don't have the same access to early detection," she added.

The Fiscal Year 1995 budget to fund activities related to NAPBC is up to \$10 million. These funds were provided as part of the National Cancer Institute appropriation.

There is a small grant initiative to support new, innovative pilot projects, the supplementation of ongoing federal grant-supported activities, and small contracts for workshops, surveys, and reports. Projects, regardless of how they are funded, will address one or more of the six priority areas. The most recent deadline for proposals was in June, and final recommendations for FY95 funding will be made before September 30, 1995.

For more information on NAPBC, contact the Office on Women's Health, Hubert H. Humphrey Building, Rm. 303-B, 200 Independence Avenue, SW, Washington, DC 20201, 202-401-9587.

PHS Activities and Programs on Breast Cancer

Agency for Health Care Policy and Research (AHCPR). AHCPR has developed and disseminated clinical practice guidelines on quality determinants of mammography for consumers and health care providers. The agency also supports research projects related to breast cancer, such as barriers to cancer screening among low-income minority women and methods to improve the use of screening

mammography by primary care physicians.

Centers for Disease Control and Prevention (CDC). CDC implements the National Breast and Cervical Cancer Early Detection Program which enables states, territories, and tribal organizations to build a public health infrastructure to increase access to screening and follow-up services, particularly for women of low income, racial and ethnic minorities, and older women. The program helps improve quality assurance measures for mammography and cervical cytology and increase education programs for women and health care providers.

Food and Drug Administration (FDA). The FDA issued regulations to implement the Mammography Quality Standards Act of 1992, which is intended to ensure safe, accurate, and reliable mammography on a nationwide basis. The act requires the establishment of a federal certification program for mammography facilities; regulations and standards for accrediting mammography facilities; and standards for mammography equipment, personnel, and practices.

National Institutes of Health (NIH). The National Cancer Institute (NCI) of NIH supports research on the role of genetics, environment, and hormones in the development of breast cancer; the implementation of primary prevention and treatment clinical trials; the accessibility and delivery of appropriate medical care to medically underserved women. Also under investigation at the agency is the role of environmental factors and diet in the development of cancer.

Health Care Financing Administration (HCFA). HCFA's Medicare Program supports

mammography through reimbursement for screening and diagnostic mammograms, and has developed an educational campaign for older women to promote the use of this screening benefit. In addition, HCFA is collaborating with NCI to develop a database that links Medicare data with tumor registry data in order to evaluate the costs of cancer care and accessing cancer prevention and treatment services.

Health Resources and Services Administration (HRSA). HRSA administers the Maternal and Child Health Services Block Grant to the States, through which screening for breast cancer is included as part of the delivery of health services to women.

Indian Health Service (IHS). The IHS collaborates with CDC's National Breast and Cervical Cancer Early Detection Program to bring mammography services to American Indian and Alaska Native women. Mobile mammography units are used to bring services to women living in remote reservation sites. IHS has also established the Alaska Native Cancer Surveillance Project, a comprehensive cancer registry for all American Indians/Alaska Natives.

Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA provides mental health services to women with breast cancer and explores the role of social support in prevention and treatment of the disease. The agency also provides information about the possible role of alcohol consumption as a risk factor for breast cancer. ■

For phone numbers and addresses of the PHS agencies listed above, call the Office of Minority Health Resource Center at 1-800-444-6472.

Stages of Breast Cancer

Stage I: Breast tumor of any size up to five centimeters, minimal skin involvement, no muscle or chest wall attachment. No axillary nodes palpable. No distant metastasis (the spread of cancer from one part of the body to another).

Stage II: Breast tumor of any size up to five centimeters, minimal skin involvement, no muscle or chest wall attachment. One or more nodes palpable in the axilla (underarm). No distant metastasis.

Stage III: Breast tumor over five centimeters. One or more nodes palpable in the axilla plus one or more of the following: skin ulceration, skin edema, pectoral muscle attachment, nodes fixed in the axilla.

Stage IV: Spread of cancer beyond the axilla (distant metastasis to bone, lung, brain, liver, etc.)

Source: *Breast Cancer/Black Woman*

Breast Cancer in African Americans

African American women under the age of 35 are one and a half times more likely to contract breast cancer than white women in that age bracket. At initial diagnosis, black women are one and a half more likely than whites to have Stage III disease and twice more likely to have Stage IV disease.

Moreover, studies have shown that in comparison with white women being treated at Stage I and Stage II, African American women have worse outcomes, though they are being treated at the same stages.

In response to these staggering discrepancies, Edwin T. Johnson, M.D., wrote a book called *Breast Cancer/Black Woman, A Primer to Help the African American Woman Survive Breast Cancer*.

"I reviewed the medical literature, and sought the opinion of leading authorities and colleagues," writes Dr. Johnson. "I talked to nurses and therapists. I interviewed cancer patients and their families; and pondered my own personal surgical experience in treating breast cancer, which was occasionally rewarding, but too often too late and tragic."

Dr. Johnson, a board certified general surgeon and specialist in breast diseases, is director of the Montgomery Urgent Care and Diagnostic Center in Montgomery, Alabama.

"Too many black women are lost to breast cancer because so many are unaware of the danger signals and too few are being checked on a regular basis," he states.

Dr. Johnson presents some of the barriers women are up against through case examples that are based on factual interviews with breast cancer patients. One woman says she found a lump in her breast, but forgot about it until she noticed how much it had grown six months later. Even then, she didn't tell her doctor because she hoped it would go away. By the time she did tell, a year had passed. She later underwent surgery to have her breast removed, and reveals that her health care providers never presented her with other treatment options. "I never thought to question anything," she says.

Another woman tells the story of how the receptionist asked about problems with her breasts "right out in front of everyone in the waiting room." When told she had to tell the receptionist before speaking with the doctor, she felt so embarrassed that she left and never returned. She ended up having a radical mastectomy.

Along with exploring the patient point of view, the book describes how a diagnosis is made, explains risk factors, presents treatment options, and offers advice for seeking emotional support. ■

For information on how to obtain *Breast Cancer/Black Woman*, call the OMH Resource Center at 1-800-444-6472.

Funding Alert

National Cancer Institute, National Institutes of Health

Cancer Control Research Small Grants. These grants fund studies that investigate cancer prevention; early detection and screening; health promotion interventions; and smoking cessation programs. The grants are open to public and private, non-profit and for-profit institutions, including hospitals, colleges, universities, and state and local governments. **Next deadlines: Oct. 1 and Feb. 1.** Contact: The Prevention and Control Extramural Research Branch, Division of Cancer Prevention and Control, NCI, Room 330, Executive Plaza North (EPN), Bethesda, MD 20892-7346, 301-496-8520.

Cancer Risk Reduction for High Risk Youths Grant. This grant funds the generation, survey, and dissemination of effective cancer risk-reduction procedures and materials for high-risk youths. Sites may include community health centers, schools, and community youth organizations. Research may target poor diet and alcohol and tobacco use among youths. **Next deadlines: Oct. 1 and Feb. 1.** Contact: Division of Cancer Prevention and Control, National Cancer Institute, EPN., Room 232, Bethesda, MD 20892, 301-496-8584.

Minority Enhancement Award. The purpose of this award is to expand minority involvement in cancer control research. Applications are accepted from institutions capable of accessing large minority populations on a regular basis. General research objectives include, but are not limited to, smoking behavior in minority youths; studies of communication strategies for presenting information to minorities about cancer prevention; investigations of patient perspectives of cancer risks; the design and evaluation of interventions to minimize and prevent distress of minority patients with cancer; the

development of pilot studies for minority clinical prevention trials; and psychosocial studies and perception of cancer risks in minorities. Contact: NCI, Division of Extramural Activities, EPN, Room 620, Bethesda, MD 20892, 301-496-7344.

Minority Health Professional Training Initiative. This initiative aims to address the low numbers of minority clinicians, clinical researchers, and other health professionals engaged in research in oncology or with training in subspecialties related to cancer. Minority investigators, defined as U.S. citizens who are African American, Hispanic/Latino, Asian American, Native American, or Pacific Islander. Contact: NCI, Division of Extramural Activities, EPN, Room 620, Bethesda, Maryland 20892, 301-496-7344.

Additional Sources

The Alexander and Margaret Stewart Trust Foundation supports efforts related to cancer prevention and the care of cancer patients. Funding is given primarily in the Washington DC metropolitan area. Application form required. **Deadline: Sept. 15.** Contact: Executive Secretary, First American Bank,

N.A., Trust Department, 20 Chevy Chase Circle, NW, Washington, DC 20015, 202-686-1552.

The Fan Fox and Leslie R. Samuels Foundation provides grants for a range of programs, including those that support cancer research related to treatment. General operating support, program development funds are available. Giving is limited to New York, NY. **Next deadlines: Sept. 15 and Dec. 15.** Contact: The Fan Fox and Leslie R. Samuels Foundation at 630 Fifth Ave., Suite 2255, New York, NY 10111-0002, 212-315-2940.

The Oncology Nursing Foundation offers Ethnic Minority Bachelor's Scholarships to provide financial assistance to ethnic minorities undergraduate studies in nursing. Candidates must have a demonstrated interest and commitment to cancer nursing, be a registered nurse, be enrolled in an undergraduate nursing degree program, must have a current license to practice as a registered nurse, and be a member of an ethnic group. **Next Deadline: Feb. 1.** Contact: Oncology Nursing Foundation, Scholarship review Committee, 501 Holiday Drive, Pittsburgh, PA 15220-2749, 412-921-7373. ■

Publications Available from CDC

- CDC, *Chronic Disease in Minority Populations*, 1994
- CDC, *Resources for Reaching Special Populations: Breast and Cervical Cancer Prevention and Control*, 1994
- CDC, *Prevalence of Selected Risk Factors for Chronic Disease by Education Level in Racial and Ethnic Populations—United States, 1991-1992*. MMWR, Vol. 43/No. 48, p. 894-899, 1994.
- AMC Cancer Research Center. *Breast and Cervical Screening: Barriers and Use Among Specific Populations*, 1995.
- University of Alabama. *Wellness Perspectives: Research, Theory and Practice*, "Public Education Intervention Strategies for Breast and Cervical Cancers—Special Issue." Vol. 11, Winter 1995.

To obtain a copy of these publications, contact CDC, Mailstop K-64, 4770 Buford Highway, NE, Atlanta, Georgia 30341-3724, 404-488-4751. ■

Resources: Cancer Information

National Cancer Institute, Office of Cancer Communications, Public Inquiries Section. Bldg. 31, Room 10A24, 9000 Rockville Pike, Bethesda, Maryland 20892, 301-496-5583, 1-800-422-6237. Provides publications list and answers written and telephone inquiries.

National Cancer Institute, Cancer Information Service. 1-800-4-CANCER. Toll-free system of cancer resources.

Centers for Disease Control and Prevention, Public Inquiries. 1600 Clifton Road, NE, Atlanta, Georgia 30333, 404-639-3286. Publications: 404-639-3534.

Centers for Disease Control and Prevention, Office on Smoking and Health, MS K-50, 4770 Buford Highway, NE, Atlanta, Georgia 30341, Technical Info. Center: 404-488-5708; Publications: 404-488-5707.

Food and Nutrition Information Center, National Agricultural Library, Room 304, 10301 Baltimore Boulevard, Beltsville, Maryland 20705, 301-504-5719.

National Institute on Aging, Public Information Office, Building 31, Room 5C27, 9000 Rockville Pike, Bethesda, Maryland 20892, 301-496-1752.

American Association for Cancer Education, University of Texas MD Anderson Cancer Center, Box 189, 1515 Holcombe Boulevard, Houston, Texas 77030-4095, 1-713-792-3020.

American Cancer Society. 1599 Clifton Road, NE, Atlanta, Georgia 30329-4215, 1-800-ACS-2345, 404-320-3333.

American Lung Association. 432 Park Avenue South, 8th Floor, New York, NY 10016, 212-889-3370. Contact your local chapter by phoning 1-800-LUNG-USA.

National Coalition for Cancer Survivorship. 323 - 8th Street, SW, Albuquerque, New Mexico 87102, 505-242-3263.

The Susan G. Komen Breast Cancer Foundation. 5005 LBJ Freeway, Suite 370, Dallas, Texas 75244, 214-450-1777.

The Breast Cancer Resource Committee. 1765 N Street, NW, Suite 100, Washington, DC 20036, 202-463-8040. ■

Cancer Surveillance:

The Centers for Disease Control and Prevention's (CDC) National Program of Cancer Registries (NPCR) serves as a fundamental part of national surveillance efforts. Cancer surveillance refers to the ongoing, timely, and systematic collection and analyses of cancer incidence and mortality data. The final link in the surveillance chain is the application of data to prevention and control programs. With fiscal year 1995 funds, 42 states and the District of Columbia are currently receiving CDC support for cancer registries. The NPCR, when fully operational in all funded states, will collect incidence data on 93 percent of the U.S. population, including first course of treatment and stage at diagnosis. The program will provide information to permit additional analyses on cancer as it relates to race and ethnicity. These registries will complement existing ones such as the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program. SEER gathers data on a sample of the population in five states and six metropolitan areas. To ensure coordination of efforts, CDC also works closely with other federal agencies and national organizations, including the North American Association of Central Cancer Registries, the American Cancer Society, the American College of Surgeons, the National Cancer Registrars' Association. ■

Conferences

August: 3-6: Annual Convention: Women and Children's Health, Washington, DC. Contact: National Black Nurses Association, 202-393-6870.

4-9: Annual Conference: Journey to Wellness, Restoring Our Mind, Body and Spirit. Mescalero, New Mexico. Contact: Association of American Indian Physicians, 405-946-7042.

8-12: National Native American/First Nations Cultural Curriculum Development Workshop, San Diego, California. Contact: United Indian Council, 1-800-523-7363, ext. 4127.

September: 6-7: International Workshop on Health Education Messages Related to Prostate Cancer, Atlanta, Georgia. Contact: Professional and Scientific Associates, 404-633-6869.

8-13: 26th Annual Conference, Chicago, Illinois. Contact: The National Association of Community Health Centers, 202-659-8008.

29-Oct. 1: National Conference on Prostate Cancer, Philadelphia, Pennsylvania. Contact: American Cancer Society, 404-329-7604.

For a comprehensive calendar of conferences, call the OMH Resource Center at 1-800-444-6472. ■

Mailing List Update

To continue to receive this publication, please indicate any address changes on the mailing panel, indicate occupational affiliation and professional interests, and return a copy of this page to the OMH Resource Center.

OCCUPATIONAL AFFILIATION

- ☐ (A) Federal government agency
- ☐ (B) State government agency
- ☐ (C) Local government agency
- ☐ (D1) Professional society
- ☐ (D2) Trade association
- ☐ (D3) Voluntary organization
- ☐ (D4) Community-based organization
- ☐ (D5) Business
- ☐ (D6) Foundation
- ☐ (D7) National nonprofit
- ☐ (D9) Primary/Secondary school
- ☐ (E1) Health center/Medical clinic
- ☐ (E2) Academic health center
- ☐ (F) Academic institution
- ☐ (G1) Print media
- ☐ (G2) Broadcast media
- ☐ (G3) Science and health writer
- ☐ (O) Other _____

HEALTH PROBLEM AREAS

- ☐ (P) ALL areas listed below
 - ☐ (P1) Cancer
 - ☐ (P2) Heart disease/stroke
 - ☐ (P3) Alcohol & other drug abuse
 - ☐ (P4) HIV infection/AIDS
 - ☐ (P5) Diabetes
 - ☐ (P6) Homicide & suicide
 - ☐ (P7) Unintentional injuries
 - ☐ (P8) Infant mortality
 - ☐ (P9) Men's health
 - ☐ (P10) Nutrition
 - ☐ (P11) Adolescent health
 - ☐ (P12) Women's health
 - ☐ (Q1) Health professionals
 - ☐ (Q2) Statistical data
 - ☐ (Q4) Access to and financing of health care
 - ☐ (Q5) Rural health
 - ☐ (Q6) Policy
 - ☐ (Q7) Information and education
 - ☐ (Q8) Demonstrations (i.e., direct services, health projts.)
- ☐ (QO) _____

MINORITY GROUPS

- ☐ (R) ALL minority groups
- ☐ (R1) ASIAN AMERICANS/
PACIFIC ISLANDERS
 - ☐ (R11) Chinese
 - ☐ (R12) Japanese
 - ☐ (R13) Filipinos
 - ☐ (R14) Vietnamese
 - ☐ (R15) Koreans
 - ☐ (R16) Pacific Islanders
- ☐ (R2) AFRICAN AMERICANS
- ☐ (R3) HISPANICS/LATINOS
 - ☐ (R31) Mexican Americans
 - ☐ (R32) Cuban Americans
 - ☐ (R33) Puerto Ricans
 - ☐ (R34) Central Americans
 - ☐ (R35) South Americans
- ☐ (R4) NATIVE AMERICANS
 - ☐ (R41) American Indians
 - ☐ (R42) Native Hawaiians
 - ☐ (R43) Alaska Natives
- ☐ (RO) OTHER

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